TOTAL MOTION THERAPIES LLC

Providing specialized Physical Therapy:

Fascial Strain-Counterstrain
Total Motion Release
Mobilizations with Movement
Myofascial Release

Date: _____

Patient: _____ DOB: _____

Address: _____

City: _____ State: _____ ZIP code: _____

Phone: Home: _____ Cell: _____

Email address: _____

Referring physician (if any): _____

INSURANCE INFORMATION (complete only if Worker's Compensation/Motor Vehicle Accident)

Employer: _____

Primary Insurance: _____

Subscriber/ID Number: _____ Group Number: _____

Policy Holder (if other than yourself): _____ Date of birth: _____

Relationship to you: _____

Secondary Insurance: _____

Subscriber/ID Number: _____ Group Number: _____

Policy Holder (if other than yourself): _____ Date of birth: _____

Relationship to you: _____

Is this a: Employment injury (Worker's Compensation)? : _____ Motor vehicle accident injury?: _____

If yes to either above: Claim Number: _____

Claim Adjuster: _____ Phone #: _____

Attorney: _____ Phone #: _____

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Payment Agreement

Thank you for choosing Total Motion Therapies, LLC as your physical therapy provider. Before we begin services, please sign below indicating you have read, understand and agree to the following payment policies.

§ You agree to be financially responsible for all charges regardless of any applicable insurance or benefit payments, third-party interest, or the resolution of any legal action or lawsuits in which you may be involved.

§ Payment is expected at time of service unless you have made other payment arrangements with us.

§ **Out-of-Network Policy.** (Commercial Health Plans - Does not apply to Medicare) **We are out-of-network with all health plans**. If you have out-of-network benefits, we will provide you with a copy of your bill that you can, at your discretion, submit to your health plan for reimbursement for the services your health plan covers. You understand that you may be required to pay a higher copay or coinsurance for out of network services if you have any out of network benefits at all. You are responsible for contacting your insurance company to determine what your benefits are and obtain any necessary physician referrals and/or pre-authorizations for services. We are not responsible if your health plan denies, in whole or in part, your claims for our services.

§ **Medicare Policy (for Medicare Part B and Medicare Advantage Plans).** If you are a Medicare beneficiary, you understand that **our licensed physical therapists are *not* enrolled as Medicare providers.** Medicare has onerous technical and administrative requirements that must be met for services to be considered medically necessary covered benefits. We believe those requirements take unnecessary time away from the services we provide. Since we are not enrolled providers, **we cannot submit claims to Medicare *and* Medicare will not pay for our services even though the same services might be paid by Medicare if you obtained them from a Medicare enrolled provider.** If you want Medicare to pay for services that might be considered covered benefits, you should seek those services from a Medicare enrolled provider. If you decide at any point after you start services with us that you want Medicare to pay for the services it covers, we will be happy to recommend a Medicare enrolled provider and terminate your services with us. As a condition of us providing services to you, you are choosing, of your own free will, not to use your Medicare benefits and agreeing to pay privately at the time of service for all services you elect to receive from us with no expectation that Medicare will reimburse you. You understand that we will not submit claims to Medicare on your behalf and agree that you, your caregivers, family members, authorized representatives or power of attorney will not, under any circumstance, submit our claims, invoices, receipts or statements to Medicare for reimbursement or to obtain a denial for a Medicare supplemental insurance plan.

- **Medicare supplemental insurance plans.** If your Medicare supplemental insurance plan will reimburse you for medically necessary services by providers not enrolled with Medicare, we will provide you with a letter stating we are not enrolled as a Medicare provider and a statement that you can submit to your supplemental plan. However, you should be prepared that your supplemental plan may not pay for services by providers not enrolled with Medicare. If your supplemental plan requires you to obtain a denial from Medicare before it will pay for your services, we cannot submit a bill to Medicare merely to get a denial because we are not enrolled providers.

o **Medicare as a Secondary Payer.** If you have a commercial insurance plan, we will provide you with a copy of your bill that you can, at your discretion, submit to your commercial health plan for reimbursement for the services your health plan covers. However, since we are not Medicare enrolled providers, Medicare will not pay your copays, co-insurance or deductibles as a secondary payer. You agree that you, your caregivers, family members, authorized representatives or power of attorney will not, under any circumstance, submit our claims, invoices, receipts or statements to Medicare for reimbursement of copays, coinsurance or deductibles that your commercial health plan does not pay.

§ **Privacy Rights.** You have a right to privacy under the Health Insurance Portability and Accountability Act (HIPAA) that includes restricting disclosure of your records and claims to your health plan, including Medicare, if you pay privately for your services at the time of service. If you pay for your services at the time of service, we assume you are exercising this right to privacy we will not disclose your medical records to any third party, including your health insurance carrier or Medicare. If you want your records disclosed to any third party in the future, you will need to obtain and sign our Authorization to Release Protected Health Information form before we will disclose your health information.

§ **Appeals Policy.** You understand that you are responsible for filing all appeals of adverse benefit determinations. If you need assistance filing an appeal with your health plan, contact the consumer assistance agency on your denial letter.

I HAVE READ, UNDERSTAND AND AGREE TO THESE PAYMENT TERMS.

I acknowledge that I have chosen, of my own free will, to obtain the services provided by Total Motion Therapies, LLC and have agreed to pay out of pocket for my services without any expectation that my health plan will reimburse me. If I am a Medicare beneficiary, I attest that I have chosen not to use my Medicare benefits for the services I am purchasing and am restricting Total Motion Therapies, LLC and my therapist from submitting any claims to Medicare pursuant to my right to privacy under HIPAA.

Patient Name (Print or Type): _____

X _____ Date: _____

Patient's Signature

A photocopy of this agreement is to be considered valid, the same as if it was the original.

TOTAL MOTION THERAPIES
844-244-4888

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Consent to Physical Therapy treatment

Fascial Counterstrain (FCS) is a gentle, manual, treatment technique that identifies and alleviates fascial restrictions of the body by relaxing dysfunctional protective "spasms." Utilizing light hands-on contact, anatomical structures are identified, slackened and held for 30 - 60 seconds in order to alleviate pain, reduce swelling, improve circulation, increase range of motion and restore pain-free function. Depending on the structures targeted, contact may include the cranium (head), chest wall/rib cage, abdomen, pelvis, pelvic floor and/or buttocks. Treatment will be provided through clothing as much as possible, and additional padding with the use of towels or pillowcases may be utilized. On some occasions patients report diffuse soreness, an increase in pain or a shifting of pain following treatment. I understand this is a normal result of treatment as mechanical stress locations change in the body, along with swelling and inflammation being released from the body.

I have the right to refuse FCS treatment to any area of the body. If I am uncomfortable with any aspect of treatment, I will advise my attending therapist in advance of my treatment so that the treatment session may be modified or so that I may be referred for alternative treatment. Refusal of treatment on a specific area will not the terminate or affect my relationship with Total Motion Therapies.

General consent:

By signing below, I hereby consent to evaluation and treatment of my condition by my attending therapist (a physical therapist license in the state of Wisconsin). Treatments offered may include FCS, additional manual therapies, exercises, ultrasound, electrical stimulation, traction. I understand the expected benefits, alternatives, and possible risks of discomfort, which may result from any form of physical therapy, including FCS treatment.

I acknowledge and understand that there is no guarantee that the proposed course of treatment will improve my condition. If any post-treatment discomfort does not subside in 1-3 days, I agreed to contact my attending therapist for the purpose of reevaluation, medical referral or a change in plan of care.

By signing below, I acknowledge that I have read and understand the above language of this "Consent to Physical Therapy Treatment" and that the benefits and risks of physical therapy FCS have been explained to me. Effective on the date below and continuing until I revoke this document in writing, I hereby consent to physical therapy treatment including Fascial Counterstrain. I agree to update my medical status or condition, with any changes that may affect my treatment. If, at any time, I elect to modify or terminate treatment, I may do so by notifying my attending therapist.

PATIENT NAME _____

PATIENT RELATIONSHIP _____

AUTHORIZED SIGNATURE _____ DATE _____

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Consent for E-mail/Text Communication and Appointment Reminders

We respect the privacy rights of all our patients and will therefore only communicate with patients and parents/guardians through email, text or voice mail messaging with your written consent. Email can be inherently insecure if your email service does not use encryption. Also, if your email address is through your employer, your employer may have access to your email box. Voice mail may also be insecure, especially if you use a VOIP phone service. When you consent to communicating with us by email, text or phone, you are agreeing to accept the risk that your protected health information may be intercepted by persons not authorized to receive such information. Since we do not control the email and phone systems you use, we are not responsible for any privacy or security breaches that may occur through voicemail, email or text communications that you have consented to.

You may choose to limit the type of voicemail, email or text communication you have with us if you wish to limit your risk of exposing your protected health information to unauthorized persons. Please indicate below what types of correspondence you consent to receive by email or text.

I do not consent to any voicemail, email or texting communication.

I consent to receiving communication about the scheduling of appointments (limiting the information disclosed) by the following means: (check all that you consent to)

Email____ Text ____ Voicemail____

I consent to all communication, including but not limited to communication about my medical condition and advice from my health care providers by the following means: (check all that you consent to)

Email____ Text ____ Voicemail____

E-mail address: _____

Phone number: _____

Patient Signature: _____ Date_____

Parent/Guardian Signature:_____ Date_____

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Assumption of the Risk and Waiver of Liability Relating to Coronavirus/COVID-19

The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization (WHO). **COVID-19 is extremely contagious** and is believed to spread mainly from person-to-person contact. Therefore, in the best interests of all our patients and staff, Total Motion Therapies, LLC has put in place additional sanitization/safety policies and procedures to minimize the risk of contracting and spreading the virus. Hand sanitizer is available for patient use. Please understand that despite taking all CDC recommended precautions, the virus can be spread by asymptomatic people. Therefore, no business can guarantee their environment will always be virus-free. By attending therapy, you acknowledge acceptance of the risk of exposure to COVID-19 and agree to waive any and all liability claims against Total Motion Therapies, LLC, its owners, employees, contractors, sublessees and patients/visitors. Please sign below indicating your acceptance of the risks. If you do not agree to accept the risks, do not schedule therapy appointments.

I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that I may be exposed to or infected by COVID-19 by attending therapy and that such exposure or infection may result in personal injury, illness, permanent disability, and death. I understand that the risk of becoming exposed to or infected by COVID-19 at Total Motion Therapies, LLC may result from the actions, omissions, or negligence of myself and others, including, but not limited to, Total Motion Therapies, LLC employees, contractors, sublessees, other patients/clients and clinic visitors. I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to myself, including, but not limited to, personal injury, disability, and death, illness, damage, loss, claim, liability, or expense, of any kind ("Claims"), that I may experience or incur in connection with my participation in therapy. I hereby release, covenant not to sue, discharge, and hold harmless Total Motion Therapies, LLC, its owners, employees, contractors, sublessees, patients/clients and clinic visitors, of and from the Claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating thereto. I understand and agree that this Agreement includes any Claims based on the actions, omissions, or negligence of Total Motion Therapies, LLC, its owners, employees, contractors, sublessees, patients/clients and clinic visitors, whether a COVID-19 infection occurs before, during, or after participation in any therapy program. I understand and agree that the laws of the State of Wisconsin will apply to this Agreement

_____

Name of patient

_____

Signature of Patient Date

I am the parent or legal guardian of the minor named above. I have the legal right to consent to and, by signing below, I hereby do consent to the terms and conditions of this Release.

_____

Signature of Parent or Guardian

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No-Show/Late Cancellation Fees

If you need to cancel your appointment, please leave a voicemail message at Total Motion Therapies: **844-244-4888**. **Please do not send a text to this number.** The voicemail is available 24 hours a day/7 days a week. You can also send an email to **jrolefson@totalmotiontherapies.com**

No-Show: If you do not attend your scheduled appointment and do not leave a voicemail or send an email prior to the appointment, you will be charged a $40 fee

Late cancellation: If you cancel your scheduled appointment by voicemail or email less than 18 hours before the appointment time you will be charged a $20 fee.

You can choose to have text and/or email reminders sent to you 24 hours before your appointments to assist you in this effort.

Any fees will be due at the start of the next therapy session or billed if it is the last scheduled appointment.

I fully understand this no-show/late cancellation fee policy.

Name : _____

Signature: _____ Date: _____

Clinic Site: Innovative Pain Care | 3111 W. Rawson Ave. Ste 235 | Franklin, WI 53132 Phone (844) 244-4888 | Fax (414) 488-1410

PATIENT HISTORY FORM

Please describe your primary problem and all related symptoms: _____

_____

_____

How and when did your primary problem begin (if it has occurred more than once include the very first time you had pain in this area as well as the most recent episode):

_____

_____

_____

_____

Rate your pain on a scale of 0 (no pain) to 10 (so severe you would go to the emergency room):

At your WORST: ____/10 Your pain is WORST when: _____

_____

_____

At your LEAST: ____/10 (if your pain comes and goes this would be "0"). Your pain is LEAST when: _____

_____

Is there anything you can do to ease your pain (please specify)?: _____

_____

Does your pain affect your sleeping? Y / N
If yes, how many times per night do you awaken from pain? _____

If you are working, what is your occupation and duties?

_____

_____

_____

If you are not working, is this due to your condition? Y / N Are you on disability? Y / N
Are you retired? Y / N Any specific notes? _____

_____

What previous treatments have you had for this condition (please also note the results)?

_____

_____

_____

_____

Please note your past medical history including any conditions (such as diabetes, high blood pressure, IBS, etc), any surgeries, and any significant accidents (falls, car accidents, etc):

Please list ALL of your current medications (not just for the condition you are being seen for here) or provide a list with this form (dosages not required):

What is your current living situation?

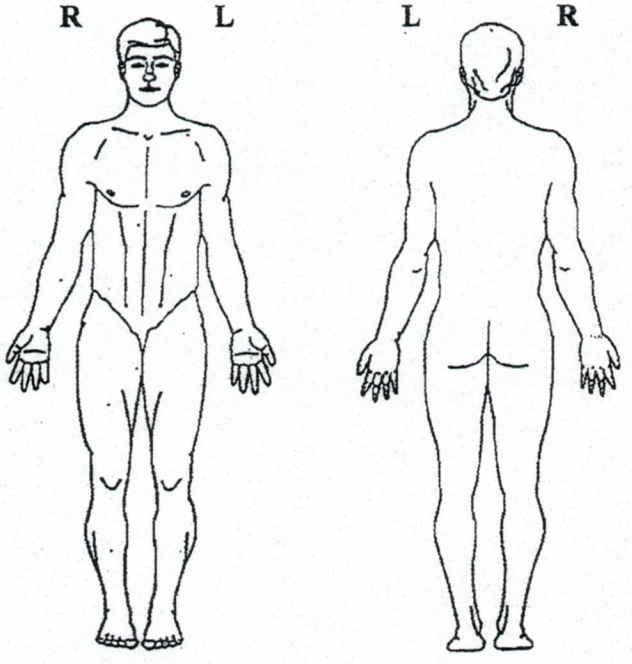
I live alone _____ I live with a spouse/ significant other/roommate _____

I am the primary caregiver _____ I receive help for my more strenuous activities _____

I live in a: Private home ____ Private apartment/condo _____ Assisted living facility _____

OTHER NOTES:

***Shade problem areas**
***Identify with an arrow, direction of pain**



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Notice of Privacy Practices Acknowledgement

I acknowledge that I have been given a copy of, or an opportunity to read, the practice's Notice of Privacy Practices.

_____

Patient Name

_____

Patient's or Guardian's Signature Date

Clinic Site: Innovative Pain Care | 3111 W. Rawson Ave. Ste 235 | Franklin, WI 53132 Phone (844) 244-4888 | Fax (414) 488-1410

TOTAL MOTION THERAPIES, LLC
Notice of Privacy Practices

Effective Date: 8/20/22

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

If you have any questions about this notice, please contact our privacy officer:

Joel Rolefson, PT, TMRc
3111 W. Rawson Ave., Suite 235
Franklin, WI 5313
(844) 244-4888

1. Summary of Rights and Obligations Concerning Health Information. Total Motion Therapies, LLC is committed to preserving the privacy and confidentiality of your health information, which is required both by federal and state law. We are required by law to provide you with this notice of our legal duties, your rights, and our privacy practices, with respect to using and disclosing your health information that is created or retained by **Total Motion Therapies, LLC**. Each time you visit us, we make a record of your visit. Typically, this record contains your symptoms, examination and test results, our assessment of your condition, a record of your treatment interventions, and a plan for future care or treatment. We have an ethical and legal obligation to protect the privacy of your health information, and we will only use or disclose this information in limited circumstances. In general, we may use and disclose your health information to:

- plan your care and treatment;
- provide treatment by us or others;
- communicate with other providers such as referring physicians;
- receive payment from you, your health plan, or your health insurer;
- make quality assessments and work to improve the care we render and the outcomes we achieve, known as health care operations;
- make you aware of services and treatments that may be of interest to you; and
- comply with state and federal laws that require us to disclose your health information.

We may also use or disclose your health information where you have authorized us to do so.

Although your health record belongs to **Total Motion Therapies, LLC**, the information in your record belongs to you. You have the right to:

- ensure the accuracy of your health record;
- request confidential communications between you and your physician and request limits on the use and disclosure of your health information; and
- request an accounting of certain uses and disclosures of health information we have made about you.

We are required to:

- maintain the privacy of your health information;
- provide you with notice, such as this *Notice of Privacy Practices*, as to our legal duties and privacy practices with respect to information we collect and maintain about you;
- abide by the terms of our most current *Notice of Privacy Practices*;
- notify you if we are unable to agree to a requested restriction; and
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all your health information that we maintain.

Should our information practices change, a revised *Notice of Privacy Practices* will be available upon request. If there is a material change, a revised Notice of Privacy Practices will be distributed to the extent required by law. We will not use or disclose your health information without your authorization, except as described in our most current *Notice of Privacy Practices.* In the following pages, we explain our privacy practices and your rights to your health information in more detail.

2. We may use or disclose your medical information in the following ways:

- ***Treatment.*** We may use and disclose your protected health information to provide, coordinate and manage your rehab care. That may include consulting with other health care providers about your health care or referring you to another health care provider for treatment including physicians, nurses, and other health care providers involved in your care. For example, we may we will release your protected health information to a specialist to whom you have been referred to ensure that the specialist has the necessary information he or she needs to diagnose and/or treat you.
- ***Payment.*** We may use and disclose your health information so that we may bill and collect payment for the services that we provided to you. For example, we may contact your health insurer to verify your eligibility for benefits, and may need to disclose to it some details of your medical condition or expected course of treatment. We may use or disclose your information so that a bill may be sent to you, your health insurer, or a family member. The information on or accompanying the bill may include information that identifies you and your diagnosis, as well as services rendered, any procedures performed, and supplies used. If, however, you pay cash at the time of service, we will not disclose your protected health information to your health plan or any other responsible payer unless you sign an authorization for us to do so. If we agree to await payment from your health plan or put you on a payment plan, we may provide health information to a collection agency, small claims court or other court of competent jurisdiction in the event your claims for our services are not paid within 90 days and you have not made alternative payment arrangements with us.
- ***Health Care Operations.*** We may use and disclose your health information to assist in the operation of our practice. For example, we may use information in your health record to assess the care and outcomes in your case and others like it as part of a continuous effort to improve the quality and effectiveness of the healthcare and services we provide. We may use and disclose your health information to conduct cost-management and business planning activities for our practice.

Business Associates.

- **Total Motion Therapies, LLC** sometimes contracts with third-party business associates for services. Examples include answering services, transcriptionists, billing services, consultants, and legal counsel. We may disclose your health information to our business associates so that they can perform the job we have asked them to do. To protect your health information, however, we require our business associates to appropriately safeguard your information.

- ***Appointment Reminders.*** We may use and disclose Information in your medical record to contact you as a reminder that you have an appointment. We usually will call you at home the day before your appointment and leave a message for you on your answering machine or with an individual who responds to our telephone call. However, you may request that we call you only at a certain number or that we refrain from leaving messages and we will endeavor to accommodate all reasonable requests.

- ***Treatment Options.*** We may use and disclose your health information in order to inform you of alternative treatments.

- ***Release to Family/Friends.*** Our staff, using their professional judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, your health information to the extent it is relevant to that person's involvement in your care or for payment related to your care. We will provide you with an opportunity to object to such a disclosure whenever we practicably can do so. We may disclose the health information of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law. However, please note that state law may prohibit us from disclosing medical information to a parent or guardian at the child's request if the child is of a certain age.

- ***Newsletters and Other Communications.*** We may use your personal information in order to communicate to you via newsletters (including electronic newsletters – subject to applicable anti-spam laws), mailings, or other means regarding treatment options, health related information, disease management programs, wellness programs, or other community based initiatives or activities in which our practice is participating.

- ***Disaster Relief.*** We may disclose your health information in disaster relief situations where disaster relief organizations seek your health information to coordinate your care, or notify family and friends of your location and condition. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.

- ***Marketing.*** In most circumstances, we are required by law to receive your written authorization before we use or disclose your health information for marketing purposes. However, we may provide you with promotional gifts of nominal value and market services or products to you in face-to-face communications. Under no circumstances will we sell our patient lists or your health information to a third party without your written authorization.

- ***Public Health Activities.*** We may disclose medical information about you for public health activities. These activities generally include the following:

  - licensing and certification carried out by public health authorities;
  - prevention or control of disease, injury, or disability;
  - reports of births and deaths;
  - reports of child abuse or neglect;
  - notifications to people who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
  - organ or tissue donation; and
  - notifications to appropriate government authorities if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will make this disclosure when required by law, or if you agree to the disclosure, or when authorized by law and in our professional judgment disclosure is required to prevent serious harm.

- ***Food and Drug Administration (FDA).*** We may disclose to the FDA and other regulatory agencies of the federal and state government health information relating to adverse events with respect to food, supplements, products and product defects, or post-marketing monitoring information to enable product recalls, repairs, or replacement.

- ***Workers Compensation.*** We may disclose your health information to the extent authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs established by law.

- ***Law Enforcement.*** We may release your health information:

  - in response to a court order, subpoena, warrant, summons, or similar process of authorized under state or federal law;
  - to identify or locate a suspect, fugitive, material witness, or similar person;
  - about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
  - about a death we believe may be the result of criminal conduct;
  - about criminal conduct at [name of provider];
  - to coroners or medical examiners;
  - in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime;
  - to authorized federal officials for intelligence, counterintelligence, and other national security authorized by law; and
  - to authorized federal officials so they may conduct special investigations or provide protection to the President, other authorized persons, or foreign heads of state.

- ***De-identified Information.*** We may use your health information to create "de-identified" information or we may disclose your information to a business associate so that the business associate can create de-identified information on our behalf. When we "de-identify" health information, we remove information that identifies you as the source of the information. Health information is considered "de-identified" only if there is no reasonable basis to believe that the health information could be used to identify you.

- ***Personal Representative.*** If you have a personal representative, such as a legal guardian, we will treat that person as if that person is you with respect to disclosures of your health information. If you become deceased, we may disclose health information to an executor or administrator of your estate to the extent that person is acting as your personal representative.

- ***HLTV-III Test.*** If we perform the HLTV-III test on you (to determine if you have been exposed to HIV), we will not disclose the results of the test to anyone but you without your written consent unless otherwise required by law. We also will not disclose the fact that you have taken the test to anyone without your written consent unless otherwise required by law.

- ***Limited Data Set.*** We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research, public health, and health care operations. We may not disseminate the limited data set unless we enter into a data use agreement with the recipient in which the recipient agrees to limit the use of that data set to the purposes for which it was provided, ensure the security of the data, and not identify the information or use it to contact any individual.

3. Authorization for Other Uses of Medical Information. Uses of medical information not covered by our most current *Notice of Privacy Practices* or the laws that apply to us will be made only with your **written authorization**. You should be aware that we are not responsible for any further disclosures made by the party you authorize us to release information to. If you provide us with authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose medical information about you for the reasons covered by your written authorization, except to the extent that we have already taken action in reliance on your authorization or, if the authorization was obtained as a condition of obtaining insurance coverage and the insurer has the right to contest a claim or the insurance coverage itself. We are unable to take back any disclosures we have already made with your authorization, and we are required to retain our records of the care that we provided to you.

4. Your Health Information Rights. You have the following rights regarding medical information we gather about you:

A. Right to Obtain a Paper Copy of This Notice. You have the right to a paper copy of this Notice of Privacy Practices at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy.

B. Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. This includes medical and billing records.

To inspect and copy medical information, you must submit a written request to our privacy officer. We will supply you with a form for such a request. If you request a copy of your medical information, we may charge a reasonable fee for the costs of labor, postage, and supplies associated with your request. We may not charge you a fee if you require your medical information for a claim for benefits under the Social Security Act (such as claims for Social Security, Supplemental Security Income, and any other state or federal needs-based benefit program.

If your medical information is maintained in an electronic health record, you also have the right to request that an electronic copy of your record be sent to you or to another individual or entity. We may charge you a reasonable cost based fee limited to the labor costs associated with transmitting the electronic health record.

C. Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we retain the information.

To request an amendment, your request must be made in writing and submitted to our privacy officer. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the medical information kept by or for [name of provider];
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

If we deny your request for amendment, you may submit a statement of disagreement. We may reasonably limit the length of this statement. Your letter of disagreement will be included in your medical record, but we may also include a rebuttal statement.

D. Right to an Accounting of Disclosures. You have the right to request an accounting of disclosures of your health information made by us. In your accounting, we are not required to list certain disclosures, including:

- disclosures made for treatment, payment, and health care operations purposes or disclosures made incidental to treatment, payment, and health care operations, however, if the disclosures were made through an electronic health record, you have the right to request an accounting for such disclosures that were made during the previous 3 years;
- disclosures made pursuant to your authorization;
- disclosures made to create a limited data set;
- disclosures made directly to you.

To request an accounting of disclosures, you must submit your request in writing to our privacy officer. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you would like the accounting of disclosures (for example, on paper or electronically by e-mail). The first accounting of disclosures you request within any 12-month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the accounting of disclosures. We will notify you of the costs involved and you may choose to withdraw or modify your request at that time, before any costs are incurred. Under limited circumstances mandated by federal and state law, we may temporarily deny your request for an accounting of disclosures.

E. Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. If you paid out-of-pocket for a specific item or service, you have the right to request that medical information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we are required to honor that request. You also have the right to request a limit on the medical information we communicate about you to someone who is involved in your care or the payment for your care.

Except as noted above, we are not required to agree to your request. If we do agree, we will comply with your request unless the restricted information is needed to provide you with emergency treatment. To request restrictions, you must make your request in writing to our privacy officer. In your request, you must tell us:

- what information you want to limit;
- whether you want to limit our use, disclosure, or both; and
- to whom you want the limits to apply.

F. Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by e-mail. To request confidential communications, you must make your request in writing to your provider or our privacy officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

G. Right to Receive Notice of a Breach. We are required to notify you by first class mail or by e-mail (if you have indicated a preference to receive information by e-mail), of any breaches of Unsecured Protected Health Information as soon as possible, but in any event, no later than 60 days following the discovery of the breach. "Unsecured Protected Health Information" is information that is not secured through the use of a technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the Protected Health Information unusable, unreadable, and undecipherable to unauthorized users. The notice is required to include the following information:

- a brief description of the breach, including the date of the breach and the date of its discovery, if known;
- a description of the type of Unsecured Protected Health Information involved in the breach;
- steps you should take to protect yourself from potential harm resulting from the breach;
- a brief description of actions we are taking to investigate the breach, mitigate losses, and protect against further breaches;

- contact information, including a toll-free telephone number, e-mail address, Web site or postal address to permit you to ask questions or obtain additional information. In the event the breach involves 10 or more patients whose contact information is out of date we will post a notice of the breach on the home page of our Web site or in a major print or broadcast media. If the breach involves more than 500 patients in the state or jurisdiction, we will send notices to prominent media outlets. If the breach involves more than 500 patients, we are required to immediately notify the Secretary. We also are required to submit an annual report to the Secretary of a breach that involved less than 500 patients during the year and will maintain a written log of breaches involving less than 500 patients.

5. Complaints. If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201. To file a complaint with us, contact our privacy officer at the address listed above. All complaints must be submitted in writing and should be submitted within 180 days of when you knew or should have known that the alleged violation occurred. See the Office for Civil Rights website, www.hhs.gov/ocr/hipaa/ for more information. You will not be penalized for filing a complaint.